FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040444

Facility Name: Sheridan Shores Care

Address: 5838 North Sheridan (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 769-2230 **Fax #** (773) 769-3579

IDPA ID Number: 363873049001

Date of Initial License for Current Owners: 06/04/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Date: **07/01/2003**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2003 Long Term Care Cost Report and Instructions on Diskette

Enclosed you will find a copy of the 2003 cost report and instructions on diskette. Please complete your 2003 cost report using this diskette. When you have completed the cost report, **please send in the diskette along with the paper copy of your cost report and all attachments**.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2003. It is due on September 30, 2003, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There is one 2003 cost report file on the disk you have received. The file has been created for use with Excel 97 or 2000. A copy of the 2003 cost report instructions has been included on the diskette also. The name of the file is Instr03.pdf. It has been created for use with Adobe Acrobat Reader. Please use this 2003 diskette. **Printed copies of the report from the 2002 cost report diskette or earlier diskettes will NOT be accepted.** In order to print the instructions on legal paper, open the Instr03.pdf file. Then click File-Page Setup. Then, change the paper size to legal and click OK. Otherwise, the instructions will print on letter size paper. The type may be a little small if letter size is used.

IMPORTANT NOTICE for Those facilities Receiving a Calendar 2002 Real Estate Tax Bill
Located after page 10 of the cost report on the worksheet named "RE_TAX" is the "2002 Long Term Care Real Estate Tax Statement". This year the real estate tax statement is being included in the cost report. **A separate notice requesting the submittal of this statement and the calendar 2002 tax bill will not be sent**. Please complete the "2002 Long Term Care Real Estate Tax Statement" and send it to our office along with the copies of the calendar 2002 real estate tax bills **at the same time you submit the fiscal 2003 cost report**.

If both the "2002 Long Term Care Real Estate Tax Statement" and the corresponding tax bills are not included with the 2003 cost report, the Medicaid rate will not include a component for real estate taxes. Additionally, the cost report will not be considered complete and timely filed and may be subject to Medicaid payments being withheld.

Cost Report File
Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (**Be sure to enter the IDPH licensed name of the facility. Ensure that the 7 digit IDPH ID# is correct.) When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter "various" or other text in columns 2 or 3.**

Attachments
Please include all explanations, additional details and additional schedules, including the information for owners' compensation, on the worksheets in the cost report file. Separate worksheets have been included after page 23 for the recording of this type of detail. Additionally, you may also insert these sheets in the file behind the pages to which they correspond. Please do not change the sheet names of pages 1 through 23, ReadMe or Macro. Also, do not change any range names or range references.

Page 12 and Pages 12A through 12I
Pages 12A through 12I have been set up to carry forward the totals from the previous page 12. For example, if you use pages 12 through 12F, the total on page 12F will be your grand total building and improvements cost. Only the pages that you use will be printed when the "Print Entire Report" macro is selected. (**Note**: Page 12 - In previous years, line 36 was the total of lines 4-35. For the 2002 and 2003 cost reports, lines 4-69 will total on line 70. Line 36 can now be used to list building improvements.)

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

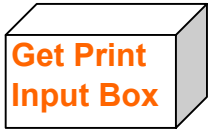
As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to the Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Cost Report File and Extra Pages
The entire cost report is in one file named Report03.xls. In an Excel 97 or 2000 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw



Shortcut=
Hold down
Control Key and press m

Shortcut=
Hold down
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To Stop Macro:
Hold down
Control Key and press "Break"

IF YOU WOULD LIKE THE NOTE, " SEE ACCOUNTANTS' COMPILATION REPORT" AT THE BOTTOM OF EVERY PAGE, ENTER THE NUMBER 1 IN CELL E4.

1

If you would like Pages Summary A and Summary B to print, change cell E11 to zero.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	127	Skilled (SNF)	127	46,355	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,537	186	1,904	15,627	8
9	SNF/PED					9
10	ICF	47,917	434		48,351	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,454	620	1,904	63,978	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.24%

D. How many bed-hold days during this year were paid by Public Aid?
1,497 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 1,904

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	203,160	22,822	8,862	234,844		234,844	91	234,935			1
2	Food Purchase		241,584		241,584	(28,361)	213,224	1,481	214,704			2
3	Housekeeping	164,421	41,161		205,582		205,582	(3,905)	201,677			3
4	Laundry	77,566	25,260		102,826		102,826		102,826			4
5	Heat and Other Utilities			158,101	158,101		158,101	1,676	159,777			5
6	Maintenance	101,704		81,706	183,410		183,410	5,561	188,971			6
7	Other (specify):*							1,196	1,196			7
8	**TOTAL General Services**	546,851	330,827	248,669	1,126,347	(28,361)	1,097,987	6,099	1,104,085			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,924,705	34,455	26,323	1,985,483		1,985,483	9,087	1,994,570			10
10a	Therapy	46,815	11,380	1,782	59,977		59,977	541	60,518			10a
11	Activities	101,518	15,077	2,328	118,923		118,923	30	118,953			11
12	Social Services	168,347		39,648	207,995		207,995	(36,083)	171,912			12
13	Nurse Aide Training											13
14	Program Transportation			83	83		83		83			14
15	Other (specify):*							1,567	1,567			15
16	**TOTAL Health Care and Programs**	2,241,385	60,912	74,964	2,377,261		2,377,261	(24,859)	2,352,402			16
	C. General Administration											
17	Administrative	89,211		66,894	156,105		156,105	(6,579)	149,526			17
18	Directors Fees											18
19	Professional Services			137,309	137,309	(4,000)	133,309	(67,244)	66,065			19
20	Dues, Fees, Subscriptions & Promotions			23,030	23,030		23,030	(4,800)	18,230			20
21	Clerical & General Office Expenses	78,469	24,997	135,983	239,449		239,449	43,949	283,398			21
22	Employee Benefits & Payroll Taxes			513,163	513,163	28,361	541,524	(378)	541,146			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,178	9,178		9,178	1,071	10,249			24
25	Other Admin. Staff Transportation			1,696	1,696		1,696		1,696			25
26	Insurance-Prop.Liab.Malpractice			197,528	197,528		197,528	1,386	198,914			26
27	Other (specify):*							16,487	16,487			27
28	**TOTAL General Administration**	167,680	24,997	1,084,781	1,277,458	24,361	1,301,819	(16,108)	1,285,711			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,955,916	416,736	1,408,414	4,781,066	(4,000)	4,777,066	(34,868)	4,742,198			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheridan Shores Care #0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,922	23,922		23,922	95,444	119,366			30
31	Amortization of Pre-Op. & Org.			551	551		551	9,759	10,310			31
32	Interest			188,010	188,010		188,010	17,566	205,576			32
33	Real Estate Taxes			253,546	253,546	4,000	257,546	2,490	260,036			33
34	Rent-Facility & Grounds			1,050,182	1,050,182		1,050,182	4,121	1,054,303			34
35	Rent-Equipment & Vehicles			3,009	3,009		3,009	2,001	5,010			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,519,220	1,519,220	4,000	1,523,220	131,381	1,654,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,187	105,176	207,363		207,363	(6,398)	200,965			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		102,187	208,106	310,293		310,293	(6,398)	303,895			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,955,916	518,923	3,135,740	6,610,579		6,610,579	90,116	6,700,695			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	86,519	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(92,248)	21		24
25	Fund Raising, Advertising and Promotional	(3,641)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(61)	20		28
29	Other-Attach Schedule	(6,307)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,761)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	105,877		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 105,877		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 90,116		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Sheridan Shores Care

ID# 0040444

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (52)	10	1
2	COPE	(2,391)	20	2
3	Collection Expense	(90)	21	3
4	Bank Charges	(3,716)	21	4
5	Theft Loss	(58)	21	5
6				6
7				7
8				8
9				9
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101	Total	(6,307)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			55		3,659	(1,863)		(1,760)				91	1
2	Food Purchase	(23)		(99)			1,603						1,481	2
3	Housekeeping					1,051			(4,956)				(3,905)	3
4	Laundry													4
5	Heat and Other Utilities			1,676									1,676	5
6	Maintenance			1,749		3,846	5		(39)				5,561	6
7	Other (specify):*					1,061	135						1,196	7
8	**TOTAL General Services**	(23)		3,381		9,617	(120)		(6,756)				6,099	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52)		221		12,145			(3,227)				9,087	10
10a	Therapy					567			(26)				541	10a
11	Activities			30									30	11
12	Social Services					(36,083)							(36,083)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					1,567							1,567	15
16	**TOTAL Health Care and Programs**	(52)		251		(21,804)			(3,254)				(24,859)	16
	C. General Administration													
17	Administrative					(6,676)	97						(6,579)	17
18	Directors Fees													18
19	Professional Services			(67,276)			32						(67,244)	19
20	Fees, Subscriptions & Promotions	(6,093)		1,284			9						(4,800)	20
21	Clerical & General Office Expenses	(96,112)		18,639		121,216	206						43,949	21
22	Employee Benefits & Payroll Taxes							(378)					(378)	22
23	Inservice Training & Education													23
24	Travel and Seminar			806			265						1,071	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,386									1,386	26
27	Other (specify):*					16,487							16,487	27
28	**TOTAL General Administration**	(102,205)		(45,161)		131,027	609	(378)					(16,108)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,280)		(41,529)		118,840	489	(378)	(10,009)				(34,868)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	**86,519**		**8,925**									**95,444**	30
31	Amortization of Pre-Op. & Org.		**9,759**										**9,759**	31
32	Interest			**17,564**			**2**						**17,566**	32
33	Real Estate Taxes			**2,490**									**2,490**	33
34	Rent-Facility & Grounds			**4,121**									**4,121**	34
35	Rent-Equipment & Vehicles			**1,949**			**52**						**2,001**	35
36	Other (specify):*													36
37	**TOTAL Ownership**	**86,519**	**9,759**	**35,049**			**54**						**131,381**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						**(2,441)**		**(3,957)**				**(6,398)**	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						**(2,441)**		**(3,957)**				**(6,398)**	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(15,761)**	**9,759**	**(6,480)**		**118,840**	**(1,898)**	**(378)**	**(13,966)**				**90,116**	45

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent Income/Expense	$ 1,056,748	Edgewater Care & Rehab Center Building, LLC	100.00%	$ 1,056,748	$	1
2	V		33	Rental Income/Exp - RE Tax	263,160	Edgewater Care & Rehab Center Building, LLC	100.00%	263,160		2
3	V		31	Amortization Expense		Edgewater Care & Rehab Center Building, LLC	100.00%	9,759	9,759	3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 1,319,908			$ 1,329,667	$ * 9,759	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 55	$ 55	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,676	1,676	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,749	1,749	17
18	V	10	Nursing	33	Care Centers, Inc.	100.00%	254	221	18
19	V	11	Activities		Care Centers, Inc.	100.00%	30	30	19
20	V	19	Professional Fees	78,480	Care Centers, Inc.	100.00%	11,204	(67,276)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	1,284	1,284	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	18,639	18,639	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	806	806	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,386	1,386	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	8,925	8,925	25
26	V	32	Interest		Care Centers, Inc.	100.00%	17,564	17,564	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,490	2,490	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,121	4,121	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,949	1,949	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food	99	Care Centers, Inc.	100.00%		(99)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 78,612			$ 72,132	$ * (6,480)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%			16
17	V	10	Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary		Care Centers, Inc.	100.00%			20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%			21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary		Care Centers, Inc.	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			24
25	V	22	Employee Benefits		Care Centers, Inc.	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 3,659	$ 3,659	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%	1,051	1,051	16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	3,846	3,846	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,061	1,061	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	12,145	12,145	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	567	567	20
21	V	12	Social Services Salary	36,252	Care Centers, Inc.	100.00%	169	(36,083)	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,567	1,567	22
23	V	17	Administration Salary	18,894	Care Centers, Inc.	100.00%	12,218	(6,676)	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	121,216	121,216	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	16,487	16,487	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 55,146			$ 173,986	$ * 118,840	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 3,436	Care Centers, Inc. - Health Systems Division	100.00%	$ 535	$ (2,901)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,603	1,603	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	5	5	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	97	97	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	32	32	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	9	9	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	206	206	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	265	265	22
23	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	2	2	23
24	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	52	52	24
25	V	39	Ancillary Enteral Supplies	4,576	Care Centers, Inc. - Health Systems Division	100.00%	2,135	(2,441)	25
26	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,038	1,038	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	135	135	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,012			$ 6,114	$ * (1,898)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 89,610	$ 89,610	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	89,988	CCS EMPLOYEE BENEFIT GROUP	100.00%		(89,988)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 89,988			$ 89,610	$ * (378)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 13,374	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 11,613	$ (1,760)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	37,651	XCEL MEDICAL SUPPLY, LLC	100.00%	32,695	(4,956)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	300	XCEL MEDICAL SUPPLY, LLC	100.00%	260	(39)	19
20	V	10	NURSING	24,519	XCEL MEDICAL SUPPLY, LLC	100.00%	21,291	(3,227)	20
21	V	10A	THERAPY	200	XCEL MEDICAL SUPPLY, LLC	100.00%	174	(26)	21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY	30,061	XCEL MEDICAL SUPPLY, LLC	100.00%	26,104	(3,957)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 106,104			$ 92,138	$ * (13,966)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	19.14%	See Attached	1.36	2.47%		$		1
2	Adam Vales	Relative	Clerical		See Attached	0.46	1.15%	Alloc Salary	359	22-7	2
3	Norm Goldberg	Owner	Administrative	2.13%	See Attached	1.50	2.83%	Alloc Salary	4,371	17-7	3
4	Mark Steinberg	Relative	Administrative		See Attached			Alloc Salary	1,696	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,426		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	$ 1,527	$	63,978	$ 55	1
2	05	Utilities	Patient Days	1,764,895	42	46,229		63,978	1,676	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251		63,978	1,749	3
4	10	Nursing	Patient Days	1,764,895	42	7,018		63,978	254	4
5	11	Activities	Patient Days	1,764,895	42	838		63,978	30	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074		63,978	11,204	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428		63,978	1,284	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091		63,978	18,639	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233		63,978	806	9
10	26	Insurance	Patient Days	1,764,895	42	38,230		63,978	1,386	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194		63,978	8,925	11
12	32	Interest	Patient Days	1,764,895	42	484,531		63,978	17,564	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681		63,978	2,490	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677		63,978	4,121	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		63,978	1,949	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,780	$		$ 72,132	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			213,393	213,393			1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			26,918				2
3	10	Nursing Salary	Direct Cost			976,718	976,718			3
4	10a	Rehab Salary	Direct Cost			103,898	103,898			4
5	11	Activity Salary	Direct Cost			10,902	10,902			5
6	12	Social Service Salary	Direct Cost			306,863	306,863			6
7	15	Emp. Ben. - Healthcare	Direct Cost			174,348				7
8	17	Administration Salary	Direct Cost			1,191,200	1,191,200			8
9	21	Office Salary	Direct Cost			698,886	698,886			9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			238,998				10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,942,124	$ 3,501,860		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	63,978	3,659	1
2	03	Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	63,978	1,051	2
3	06	Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	63,978	3,846	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		63,978	1,061	4
5	10	Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	63,978	12,145	5
6	10a	Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	63,978	567	6
7	12	Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	63,978	169	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		63,978	1,567	8
9	17	Administration Salary	Patient Days	1,764,895	42	337,043	337,043	63,978	12,218	9
10	21	Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	63,978	121,216	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		63,978	16,487	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,799,547	$ 4,272,235		$ 173,986	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579		138,556		8,012	535	1
2	02	Food	Billable Income	2,073,579		852,614		8,012	1,603	2
3	06	Maintenance	Billable Income	2,073,579		1,311		8,012	5	3
4	17	Administration	Billable Income	2,073,579		25,000		8,012	97	4
5	19	Professional Fees	Billable Income	2,073,579		8,170		8,012	32	5
6	20	Dues & Subscriptions	Billable Income	2,073,579		2,312		8,012	9	6
7	21	Office & Clerical	Billable Income	2,073,579		53,285		8,012	206	7
8	24	Travel & Seminar	Billable Income	2,073,579		68,680		8,012	265	8
9	32	Interest Expense	Billable Income	2,073,579		571		8,012	2	9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579		13,336		8,012	52	10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		8,012	2,135	11
12	01	Dietary - Salary	Billable Income	2,073,579		268,554	268,554	8,012	1,038	12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		8,012	135	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,582,287	$ 268,554		$ 6,114	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 89,610	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 89,610	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 11,613	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						32,695	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						260	5
6	10	NURSING	Direct Allocation						21,291	6
7	10A	THERAPY	Direct Allocation						174	7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation						26,104	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 92,138	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Misc.						$	$ 2,266,109			$ 138,723	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Diawa		X	Line of Credit				867,773			49,287	6
7	Care Centers Allocation		X								17,566	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 3,133,882			$ 205,576	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 3,133,882			$ 205,576	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	260,241	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	253,118	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,123)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	263,159	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	4,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	260,036	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	286,694	8
	1999	284,769	9
	2000	241,566	10
	2001	247,849	11
	2002	250,628	12

2003 accrual = 2002 tax X 1.05 ($250,628 X 1.05 = $263,159)

Allocation from Care Centers $2,490

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-402-027-0000	Long Term Care Property	$ 125,313.94	$ 125,313.94
2.	14-05-402-028-0000	Long Term Care Property	$ 125,313.94	$ 125,313.94
3.	See Attached	Home Office Allocation	$ 68,681.49	$ 2,489.73
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 319,309.37	$ 253,117.61

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: Various

3. Current Period Amortization: 10,310 4. Dates Incurred: Various

Nature of Costs: Financing Fees, Assignment Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Allocation Care Centers			16,327	2
3	TOTALS			$ 16,327	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20	2,145	2,145	22,168	9
10	Various			1994	57,552		20	2,878	2,878	27,569	10
11	Various			1995	146,433		20	7,322	7,322	63,365	11
12	Various			1996	67,704		20	3,385	(3,385)	25,711	12
13	Various			1997	53,902		20	2,696	2,696	17,655	13
14	Various			1998	172,679		20	8,637	8,637	48,325	14
15	Various			1999	62,682		20	3,134	3,134	14,296	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		69,711	2,331		2,331		2,482	68
69	Financial Statement Depreciation			23,922			(23,922)		69
70	TOTAL (lines 4 thru 69)		$ 673,537	$ 26,253		$ 32,528	$ (495)	$ 221,571	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 673,537	$ 26,253		$ 32,528	$ 6,275	$ 221,571	1
2	Paint	2000	3,760		20	188	188	752	2
3	Tv Wiring	2000	7,384		20	369	369	1,476	3
4	Paint	2000	2,956		20	148	148	567	4
5	Corners Guards	2000	2,933		20	147	147	563	5
6	Fyre-Shield	2000	987		20	49	49	189	6
7	Wallpaper	2000	22,360		20	1,118	1,118	4,193	7
8	Corner Guards	2000	3,618		20	181	181	679	8
9	Paint	2000	759		20	38	38	139	9
10	Paint	2000	(111)		20	(6)	(6)	(21)	10
11	Paint	2000	621		20	31	31	114	11
12	Paint	2000	301		20	15	15	55	12
13	Electrical	2000	2,170		20	109	109	399	13
14	Seco Refrigeration	2000	1,572		20	79	79	282	14
15	Paint	2000	700		20	35	35	125	15
16	Wiring	2000	1,225		20	61	61	215	16
17	Lift Handles	2000	1,503		20	75	75	263	17
18	Radiator	2000	8,963		20	448	448	1,568	18
19	Wiring	2000	725		20	36	36	124	19
20	Wiring	2000	500		20	25	25	85	20
21	Awning	2000	6,970		20	349	349	1,191	21
22	Camera System	2000	2,274		20	114	114	379	22
23	Hvac	2000	525		20	53	53	171	23
24	Radiator	2000	11,823		20	591	591	1,872	24
25	Refrig Renov	2000	2,254		20	113	113	442	25
26	Refrig Renov	2000	4,180		20	209	209	801	26
27	Cove Base	2000	3,200		20	160	160	600	27
28	Handrails	2000	3,911		20	196	196	718	28
29	Cove Base	2000	854		20	43	43	157	29
30	Paint	2000	1,954		20	98	98	342	30
31	Paint	2000	969		20	48	48	165	31
32	Wall Guard	2000	1,840		20	92	92	314	32
33	Drywall	2000	1,200		20	60	60	200	33
34	TOTAL (lines 1 thru 33)		$ 778,417	$ 26,253		$ 37,800	$ 11,547	$ 240,690	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 778,417	$ 26,253		$ 37,800	$ 11,547	$ 240,690	1
2	Door Holders	2000	19,985		20	999	999	3,248	2
3	Window Treatments	2000	5,587		20	279	279	908	3
4	Blower Wheels	2000	1,045		20	52	52	166	4
5	Blow Off Valve	2000	1,001		20	50	50	158	5
6	Mixing Valve	2000	3,369		20	168	168	533	6
7	Transmitter	2000	924		20	46	46	146	7
8	Motor	2000	609		20	30	30	104	8
9	Cubicles	2000	10,155		20	508	508	1,693	9
10	Hatch Sill	2000	1,970		20	99	99	321	10
11	Expansion Tank	2001	572		20	29	29	86	11
12	Pipe Insulation	2001	956		20	48	48	144	12
13	Pilot Assembly	2001	518		20	26	26	78	13
14	Motor	2001	1,135		20	57	57	171	14
15	Motor	2001	1,386		20	69	69	202	15
16	Transmitter	2001	924		20	46	46	134	16
17	Wiring	2001	1,274		20	64	64	186	17
18	Generator	2001	589		20	29	29	86	18
19	Paint	2001	924		20	46	46	127	19
20	Cubicle Curtains	2001	17,136		20	857	857	2,500	20
21	Elevator	2001	1,522		20	76	76	209	21
22	Air Conditioning	2001	1,294		20	65	65	172	22
23	Compressor	2001	1,218		20	61	61	158	23
24	Sewer Lines	2001	3,692		20	185	185	477	24
25	Window Coverings	2001	2,328		20	116	116	291	25
26	Domestic Water Pipin	2001	548		20	27	27	66	26
27	Wiring	2001	1,140		20	57	57	171	27
28	Transmitter	2001	924		20	46	46	138	28
29	Steel Door	2001	1,199		20	60	60	145	29
30	Wiring	2001	4,785		20	239	239	718	30
31	Drywall	2001	638		20	32	32	96	31
32	Flame Control Center	2001	1,402		20	70	70	193	32
33	Cubicle Curtains	2001	693		20	35	35	92	33
34	TOTAL (lines 1 thru 33)		$ 869,859	$ 26,253		$ 42,371	$ 16,118	$ 254,607	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 869,859	$ 26,253		$ 42,371	$ 16,118	$ 254,607	1
2	Fire Alarm	2001	800		20	40	40	107	2
3	Transmitter	2001	940		20	47	47	125	3
4	Flow Switch	2001	765		20	38	38	102	4
5	Steel Shutes, Door	2001	1,332		20	67	67	167	5
6	Exhaust System	2001	543		20	27	27	65	6
7	Fedders	2001	5,285		20	264	264	639	7
8	Hot Water Heater	2002	11,675		20	1,168	1,168	2,238	8
9	Toilet R & M	2002	747		20	75	75	149	9
10	Ceiling Fans	2002	700		20	70	70	140	10
11	Doors	2002	1,199		20	60	60	120	11
12	Deposit On Don Office Remodeling	2002	1,859		20	186	186	372	12
13	Water Pump Leaking	2002	2,449		20	245	245	490	13
14	Roof Maintenance	2002	3,800		20	380	380	760	14
15	Electric Wiring	2002	615		20	62	62	123	15
16	New Water Pressure Valve	2002	656		20	131	131	262	16
17	Nurse Call System	2002	2,100		20	140	140	280	17
18	Tile Outlet-Tiles	2002	990		20	66	66	127	18
19	Elevator Repair	2002	1,110		20	56	56	102	19
20	Plumbing Repair	2002	565		20	57	57	104	20
21	Boiler Repair	2002	594		20	50	50	87	21
22	Cooling Tower Repair	2002	541		20	54	54	95	22
23	A/C Repair	2002	852		20	71	71	124	23
24	Power Tron Repair	2002	1,791		20	179	179	313	24
25	Countertops	2002	2,300		20	230	230	403	25
26	Plumbing Repair	2002	690		20	69	69	115	26
27	Boiler Repair	2002	1,334		20	111	111	185	27
28	Doors	2002	1,050		20	53	53	88	28
29	Sump Pump R & M	2002	2,214		20	221	221	351	29
30	Plumbing Repair	2002	824		20	82	82	130	30
31	Plumbing Repair	2002	2,940		20	294	294	466	31
32	Antennas	2002	1,065		20	213	213	337	32
33	Door	2002	635		20	32	32	50	33
34	TOTAL (lines 1 thru 33)		$ 924,819	$ 26,253		$ 47,209	$ 20,956	$ 263,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 924,819	$ 26,253		$ 47,209	$ 20,956	$ 263,823	1
2	Hvac Feeders	2002	5,252		20	438	438	693	2
3	Freezer R&M	2002	1,848		20	264	264	396	3
4	Hvac R&M	2002	599		20	60	60	90	4
5	Antennas	2002	1,065		20	213	213	320	5
6	Timeclock Installation	2002	759		20	152	152	215	6
7	Ceiling Tile	2002	758		20	38	38	51	7
8	Powertron Repair	2002	777		20	78	78	123	8
9	Booster Circuit For Water Booster	2002	516		20	52	52	90	9
10	Leasehold Improvements	2002	3,276		20	328	328	628	10
11	Roof	2002	1,050		20	105	105	131	11
12	Vertical Blinds	2002	2,034		20	203	203	254	12
13	Boiler	2002	1,876		20	188	188	235	13
14	Drywall	2002	850		20	85	85	106	14
15	Electric	2002	826		20	165	165	207	15
16	Water Heater	2003	2,282		20	456	456	456	16
17	Keypad Panel W/ Transformer	2003	1,538		20	308	308	308	17
18	Keypad Panel W/ Transformer	2003	1,070		20	214	214	214	18
19	Plumbing Repair	2003	570		20	57	57	57	19
20	Doors	2003	1,315		20	263	263	263	20
21	Elevator Repairs	2003	1,229		20	123	123	123	21
22	Ejector Pump	2003	2,741		20	548	548	548	22
23	Boiler Repairs	2003	1,389		20	139	139	139	23
24	Water Heater	2003	808		20	148	148	148	24
25	Roofing	2003	700		20	64	64	64	25
26	Roofing	2003	700		20	58	58	58	26
27	Roofing	2003	700		20	58	58	58	27
28	First Floor Construction	2003	9,833		20	819	819	819	28
29	Pipeing	2003	5,854		20	488	488	488	29
30	Hvac Repairs	2003	2,669		20	445	445	445	30
31	Plumbing Repair	2003	670		20	112	112	112	31
32	Lobby Remodeling	2003	10,500		20	788	788	788	32
33	Bathroom Remodeling	2003	1,850		20	139	139	139	33
34	TOTAL (lines 1 thru 33)		$ 992,723	$ 26,253		$ 54,805	$ 28,552	$ 272,589	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 992,723	$ 26,253		$ 54,805	$ 28,552	$ 272,589	1
2	Painting Material	2003	542		20	81	81	81	2
3	Lobby Remodeling - Addl Work	2003	2,501		20	167	167	167	3
4	Elevator Repair	2003	661		20	88	88	88	4
5	Elevator Repair	2003	823		20	110	110	110	5
6	Wall Repair	2003	774		20	52	52	52	6
7	Cooling Tower	2003	1,652		20	220	220	220	7
8	Nurses Call Repair	2003	665		20	89	89	89	8
9	First Floor Construction	2003	588		20	34	34	34	9
10	Hot Water Heater Repair	2003	857		20	100	100	100	10
11	Birch Fire Door	2003	5,574		20	557	557	557	11
12	Parking Garage Repairs	2003	1,925		20	96	96	96	12
13	Parking Garage Repairs	2003	2,709		20	113	113	113	13
14	2 Lavatories	2003	1,216		20	101	101	101	14
15	Parking Garage Repair	2003	4,770		20	159	159	159	15
16	Boiler Repair	2003	3,630		20	242	242	242	16
17	Parts For Door	2003	784		20	52	52	52	17
18	Detector Edge In Elevator	2003	556		20	37	37	37	18
19	Storage Tank	2003	2,323		20	116	116	116	19
20	Security System Key Switches	2003	885		20	44	44	44	20
21	Door Locks	2003	2,017		20	101	101	101	21
22	Parking Garage Repair	2003	3,693		20	62	62	62	22
23	Smoke Detectors Installed	2003	4,021		20	134	134	134	23
24	Pump W/ Motor	2003	977		20	33	33	33	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,036,866	$ 26,253		$ 57,593	$ 31,340	$ 275,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC Allocation		2002		$ 25,397	$ 635	35	$ 635	$	$ 688	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main LLC Allocation			2002	23,515	1,176	20	1,176		1,274	9
10	2201 Main LLC Allocation			2003	20,799	520	20	520		520	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 69,711	$ 2,331		$ 2,331	$	$ 2,482	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 548,825	$ 3,437	$ 51,977	$ 48,540	10	$ 316,944	71
72	Current Year Purchases	62,469	303	6,942	6,639	10	6,942	72
73	Fully Depreciated Assets	6,874				10	6,874	73
74								74
75	TOTALS	$ 618,168	$ 3,740	$ 58,919	$ 55,179		$ 330,760	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers Allocation		$ 26,409	$ 2,855	$ 2,855	$	5	$ 20,781	76
77										77
78										78
79										79
80	TOTALS			$ 26,409	$ 2,855	$ 2,855	$		$ 20,781	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,697,770	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,848	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 119,367	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 86,519	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 626,918	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Sam and David Gorenstein

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	Edgewater LLC			$ 1,050,182			3
4	Additions							4
5								5
6	Allocation from Care Centers				4,121			6
7	TOTAL				$ 1,054,303 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 5,010 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 72,743	$		$ 72,743	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			68			68	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			32,365			32,365	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						102,187		102,187	13
14	TOTAL			$		$ 105,176	$ 102,187		$ 207,363	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,040	$ 4,053	1
2	Cash-Patient Deposits	1,381	1,381	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,306,514	1,306,514	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	124,621	124,621	6
7	Other Prepaid Expenses	9,590	9,590	7
8	Accounts Receivable (owners or related parties)	138,168	138,168	8
9	Other(specify): See Attached Schedule	904,007	967,382	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,488,321	$ 2,551,709	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	841,443	841,443	15
16	Equipment, at Historical Cost	707,167	707,167	16
17	Accumulated Depreciation (book methods)	(528,295)	(528,295)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		53,678	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,020,315	$ 1,073,993	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,508,636	$ 3,625,702	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 957,253	$ 957,253	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,596	143,596	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,599	20,599	31
32	Accrued Real Estate Taxes(Sch.IX-B)	263,159	263,159	32
33	Accrued Interest Payable	123,254	123,254	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	585,000	1,056,851	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,092,861	$ 2,564,712	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,133,882	3,133,882	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,133,882	$ 3,133,882	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,226,743	$ 5,698,594	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,718,107)	$ (2,072,892)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,508,636	$ 3,625,702	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,579,925)	1
2	Restatements (describe):		2
3	**Depreciation Adjustment**	5,827	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,574,098)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(144,009)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (144,009)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,718,107)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,265,919	1
2	Discounts and Allowances for all Levels	(345,632)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,920,287	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	437,919	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 437,919	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	52,021	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	56,343	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 108,364	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,466,570	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,126,347	31
32	Health Care	2,377,261	32
33	General Administration	1,277,458	33
	B. Capital Expense		
34	Ownership	1,519,220	34
	C. Ancillary Expense		
35	Special Cost Centers	207,363	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,610,579	40
41	**Income before Income Taxes (line 30 minus line 40)****	(144,009)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (144,009)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,724	1,967	$ 63,768	$ 32.42	1
2	Assistant Director of Nursing	2,672	2,909	71,740	24.66	2
3	Registered Nurses	12,512	14,106	332,470	23.57	3
4	Licensed Practical Nurses	27,140	29,956	583,887	19.49	4
5	Nurse Aides & Orderlies	85,962	95,143	845,124	8.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,539	4,106	46,815	11.40	8
9	Activity Director	1,851	2,271	37,173	16.37	9
10	Activity Assistants	8,680	9,211	64,345	6.99	10
11	Social Service Workers	11,523	12,388	168,347	13.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,211	23,408	203,160	8.68	15
16	Dishwashers					16
17	Maintenance Workers	10,765	11,752	101,704	8.65	17
18	Housekeepers	20,993	22,073	164,421	7.45	18
19	Laundry	7,929	8,243	77,566	9.41	19
20	Administrator	1,937	2,325	89,211	38.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,296	7,046	78,469	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,847	2,116	27,716	13.10	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	226,581	249,020	$ 2,955,916 *	$ 11.87	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	209	$ 8,862	01-03	35
36	Medical Director	Monthly	4,800	09-03	36
37	Medical Records Consultant	Monthly	1,032	10-03	37
38	Nurse Consultant	53	5,308	10-03	38
39	Pharmacist Consultant	Monthly	2,850	10-03	39
40	Physical Therapy Consultant	16	918	10a-03	40
41	Occupational Therapy Consultant	16	864	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,328	11-03	44
45	Social Service Consultant	60	3,396	12-03	45
46	Other(specify)				46
47					47
48	Care Centers - see attached		36,252	12-03	48
49	TOTAL (lines 35 - 48)	401	$ 66,610		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	419	17,133	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	419	$ 17,133		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Todd Tedrow	Administrator	0	$ 89,211
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,211

B. Administrative - Other

Description	Amount
Nathan Langsner - Management Fee	$ 48,000
Care Centers Payroll Adjusted Out on Page 6C	18,894
TOTAL (agree to Schedule V, line 17, col. 3)	$ 66,894
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 21,700
Care Centers Inc	Accounting	15,000
Meyer Magence	Legal	616
Sachnoff & Weaver	Legal	8,800
Winston & Strawn	Legal	590
Care Centers Inc	Bookkeeping	63,480
Personnel Planners	Unmployment Consult	1,190
ADP	Payroll	8,625
IIT / Sourcetech	Computer Support	900
Maxxsource	Computer Support	1,200
TEG Services	Utility Management Service	675
See Supplemetal Schedule		14,533
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 137,300

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,541
Unemployment Compensation Insurance	44,921
FICA Taxes	214,419
Employee Health Insurance	126,157
Employee Meals	28,361
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	6,509
Pension Expense	22,954
Misc Employee Welfare	4,072
Uniforms	212
TOTAL (agree to Schedule V, line 22, col.8)	$ 541,146

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	2,420
(Indicate # of checks performed 202)	
Dues and Subscritpions	6,610
Licenses and Fees	7,907
Allocation From Care Centers	1,284
Alloc Care Centers Health Sys	9
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,230

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,178
Allocation Care Centers	806
Allocation Care Centers Health Sys	265
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,249

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - $9,001

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 4,333 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 102,930
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 28,361 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.